Supreme Court, U.S.
FILED
JAN 28 2015
OFFICE OF THE CLERK

No. 14-114

In the Supreme Court of the United States

DAVID KING, ET AL., PETITIONERS

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF HEALTH CARE POLICY HISTORY SCHOLARS AS AMICI CURIAE SUPPORTING RESPONDENTS

BENJAMIN J. HORWICH
Counsel of Record
GUHA KRISHNAMURTHI
JOHN F. MULLER
MUNGER, TOLLES & OLSON LLP
560 Mission Street
27th Floor
San Francisco, CA 94105
ben.horwich@mto.com
(415) 512-4000

OF COUNSEL:

MARK REGAN
DISABILITY LAW CENTER OF ALASKA
3330 Arctic Blvd.
Suite 103
Anchorage, AK 99503
(907) 565-1002

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

TABLE OF CONTENTS

Page

Interest of amici curiae 1

Summary of argument 2

Argument 3

I. Drawing on earlier state experience, the 111th Congress subscribed to the widespread consensus that coverage subsidies were a necessary component of politically feasible health reform 3

II. The legislative evolution of the subsidy and exchange provisions of the Affordable Care Act 9

A. Overview of the Senate legislative process 10

B. The Senate HELP Committee bill 13

C. The Senate Finance Committee bill 14

D. The merged Senate legislation 17

E. Passage in the House and the Health Care and Education Reconciliation Act 19

III. The government's position finds support both in affirmative evidence from the legislative record and in the lack of evidence that any Member of Congress shared petitioners' understanding of the Act when it was considered and passed 20

A. This Court has appropriately relied on legislative silence to reject proposed statutory interpretations with policy consequences so significant that they could not have escaped comment during the legislative process 21

B. The legislative record conspicuously lacks any suggestion that Members understood the Act or predecessor bills as petitioners do, and indeed it speaks affirmatively against their position 23

C. Petitioners and their amici fail to identify sound evidence that any Member of Congress shared their understanding of the Act when it was considered and passed 30

Conclusion 36

Appendix — List of Amici Curiae 1a

TABLE OF AUTHORITIES

Cases: Page

Chisom v. *Roemer*, 501 U.S. 380 (1991) 22

Church of Scientology v. *IRS*, 484 U.S. 9 (1987) 21, 22

City of Rancho Palos Verdes v. *Abrams*, 544 U.S. 113 (2005) 22

Halbig v. *Burwell*, 758 F.3d 390 (D.C. Cir. 2014) 6, 35

Harrison v. *PPG Industries, Inc.*, 446 U.S. 578 (1980) 22

National Federation of Independent Business v. *Sebelius*, 132 S. Ct. 2566 (2012) 5, 12

Sedima, S.P.R.L. v. *Imrex Co.*, 473 U.S. 479 (1985) 22

United States v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944) 12

United States v. *Woods*, 134 S. Ct. 557 (2013) 35

Statutes:

Act of Mar. 9, 1945 (McCarran-Ferguson Act), ch. 20, 59 Stat. 33, 15 U.S.C. 1011 *et seq.* 12

Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts ch. 58 9

Statutes—Continued: Page

Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029:..... 10, 30
§ 1004(c), 124 Stat. 1035 (adding 26 U.S.C. 36B(f)(3)) 20
Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) 2
26 U.S.C. 36B..... 20, 24, 33

Miscellaneous:

155 Cong. Rec.:
S11916 (Nov. 21, 2009)..... 28
S12107 (Dec. 2, 2009) 28
S12358 (Dec. 4, 2009) 29
S12378 (Dec. 4, 2009) 28
S12799 (Dec. 9, 2009) 29
S13726 (Dec. 22, 2009) 29
S13832 (Dec. 23, 2009) 29
S13891 (Dec. 24, 2009) 19
156 Cong. Rec. H2153 (Mar. 21, 2010) 20
Addressing Insurance Market Reform in National Health Reform (Roundtable Discussion): Hearing of the Committee on Health, Education, Labor, and Pensions, 111th Cong. (Mar. 24, 2009)..... 11
Jonathan H. Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA*, 23 Health Matrix 119 (2013) 7
American Legislative Exchange Council & Council for Affordable Health Insurance, *2009 State Legislators' Guide to Health Insurance Solutions* (2009) 12

Miscellaneous—Continued: Page

Max Baucus, *Call to Action: Health Reform 2009* (Nov. 12, 2008) 4, 6, 7, 9, 10, 24

Robert F. Bennett et al., *Senate Republican Health Care Task Force Consensus Principles for Health Care Reform* (1993) 6

Lisa Schultz Bressman & Abbe R. Gluck, *Statutory Interpretation from the Inside: An Empirical Study of Congressional Drafting, Delegation and the Canons: Part II*, 66 Stan. L. Rev. 725 (2014) 26

Steven Brill, *America's Bitter Pill* (2015) 15

Carrie Budoff Brown, *Nelson: National Exchange a Dealbreaker*, Politico, Jan. 25, 2010 32

Stuart M. Butler, *Assuring Affordable Health Care for All Americans*, 218 The Heritage Lectures 1 (1989) 6

Sean P. Carr, *State Regulators Embrace Health Reforms, but Insist Oversight Remains with Them*, A.M. Best Newswire, Aug. 3, 2009 11

Gail Russell Chaddock, *Senate's "Gang of Six" Key to Healthcare Reform*, Christian Sci. Monitor, Aug. 8, 2009 15

Chairman's Mark, America's Healthy Future Act of 2009 (Sept. 22, 2009). 15, 24

Jonathan Cohn, *How They Did It: The Inside Account of Health Care Reform's Triumph*, The New Republic, June 10, 2010, at 14 19

Jonathan Cohn, *One More Clue that the Obamacare Lawsuits Are Wrong*, New Republic, July 28, 2014 34

Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (Nov. 30, 2009) 26

Miscellaneous—Continued: Page

Richard E. Curtis et al., *Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?*, Health Aff., Jan. 2001, at 164 8

Richard E. Curtis et al., *Private Purchasing Pools to Harness Individual Tax Credits for Consumers*, 38 Inquiry 159 (2001) 8

Arthur C. Doyle, *Silver Blaze*, in *The Complete Sherlock Holmes* 335 (1927) 22

Letter from Douglas W. Elmendorf to Hon. Darrell E. Issa (Dec. 6, 2012) 26

Alain C. Enthoven, *The History and Principles of Managed Competition*, Health Aff., Jan. 1993, at 24 7

David Espo & Richard Alonso-Zaldivar, *Nelson Supports Health Bill After Tough Bargaining*, Associated Press, Dec. 19, 2009 31

Paul Fronstin & Murray N. Ross, Employee Benefit Research Institute, *Addressing Health Care Market Reform Through an Insurance Exchange: Essential Policy Components, the Public Plan Option, and Other Issues to Consider* (June 2009) 8

H.R. 3962, 111th Cong. (as passed by House, Nov. 7, 2009): 33

§§ 301, 308 19

HELP Health Reform Legislation—Section by Section Narrative (July 15, 2009) 13, 24

House Energy and Commerce Committee, *Health Insurance Exchanges* (Mar. 20, 2010). 30

David K. Jones et al., *Pascal's Wager: Health Insurance Exchanges, Obamacare, and the Republican Dilemma*, 39 J. Health Pol. Pol'y & L. 97 (2014) 10

Miscellaneous—Continued: Page

Timothy Stoltzfus Jost, *Health Insurance Exchanges: Legal Issues*, O'Neill Institute for National and Global Health Law, Georgetown Univ. Legal Ctr., no. 23 (Apr. 7, 2009) 36

Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts*, 25 J. Health Pol. Pol'y & L. 133 (2000) 6

John E. McDonough, *Inside National Health Reform* (2011) 19

Mark V. Pauly et al., *A Plan for Responsible National Health Insurance*, Health Aff., Spring 1991, at 5 6

Jill Quadagno, *Right-Wing Conspiracy? Socialist Plot? The Origins of the Patient Protection and Affordable Care Act*, 39 J. Health Pol. Pol'y & L. 35 (2014) 4, 6

Elizabeth Rigby et al., *Party Politics and Enactment of "Obamacare": A Policy-Centered Analysis of Minority Party Involvement*, 39 J. Health Pol. Pol'y & L. 57 (2014) 8

S. 1679, 111th Cong. (as reported, Sept. 17, 2009): 13

§ 3101(c) 19

§ 3104(a)(1)(C), (2)(C) & (d)(1)(D) 14

§ 3104(b) 13

§ 3104(c) 13

§ 3104(d) 13

§ 3104(d)(1)(A)-(C) 13

§ 3104(d)(1)(D) 14

§ 3104(d)(2) 13, 14, 24

§ 3111 14

Miscellaneous—Continued: Page

S. 1796, 111th Cong. (as reported, Oct. 19, 2009): 15
§ 1001 (proposing SSA § 2200(2)) 15
§ 1001 (proposing SSA § 2225(a)(3)) 16
§ 1001 (proposing SSA § 2225(b)(1)(A)) 16
§ 1001 (proposing SSA § 2225(b)(1)(B)) 16, 18
§ 1205(a) (proposing 26 U.S.C. 36B(b)(1)) 16
§ 1205(a) (proposing 26 U.S.C. 36B(b)(2)(A) & (c)(2)(A)(i)) 18
§ 1205(a) (proposing 26 U.S.C. 36B(c)(2)(A)(i)) 16
§ 1221(a) (proposing 26 U.S.C. 45R) 28
§ 1221(a) (proposing 26 U.S.C. 45R(c)(2)) 25
S. Am. 2786 to H.R. 3590, 111th Cong. (as introduced, Nov. 19, 2009): 17
§ 1321(c)(1) 18, 19
§ 1401 (proposing 26 U.S.C. 36B(b)(1)) 16, 17, 18, 19
§ 1401 (proposing 26 U.S.C. 36B(c)(2)(A)(i)) 16, 17, 18
§ 1401 (proposing 26 U.S.C. 36B(b)(2)(A)) 18
S. Am. 3276 to S. Am. 2786 (as introduced, Dec. 19, 2009) 19
S. Rep. No. 89, 111th Cong. (2009) 17, 25
Senate Committee on Finance, *Health Care Reform from Conception to Final Passage* 14
Marilyn Werber Serafini & Bara Vaida, *Eight Key Hurdles for Health Care Overhaul*, Nat'l J., Nov. 20, 2009 27
Theda Skocpol, *Why Congressional Budget Office Reports Are the Best Evidence of Congressional Intent About Health Subsidies* 26

Miscellaneous—Continued: Page

Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (2011) 4, 6, 9

Tri-Committee House Staff, *House-Senate Comparison of Key Provisions* (Dec. 29, 2009) 30

Sally Trude & Paul B. Ginsburg, Center for Studying Health System Change, *Tax Credits and Purchasing Pools: Will This Marriage Work?* (April 2001)..... 9

U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans, My Harlingen News, Jan. 11, 2010..... 34

Matt Viser & Frank Phillips, *Senate Poll: Coakley Up 15 Points*, Boston Globe, Jan. 10, 2010..... 34

Leigh Wachenheim & Hans Leida, Milliman, Inc., *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets* (Aug. 2007)..... 5

Elliot K. Wicks & Mark A. Hall, *Purchasing Cooperatives for Small Employers: Performance and Prospects*, 78 Milbank Q. 511 (2000) 8

Written Comments of Sandy Praeger on Behalf of the National Association of Insurance Commissioners, for the Senate Finance Committee Roundtable Discussion on "Expanding Health Care Coverage" (May 2009)..... 11

Written Testimony of Professor Jonathan Gruber Before the Committee on Oversight and Government Reform, U.S. House of Representatives (Dec. 9, 2014) 35

Ron Wyden, *Health Reform's Missing Ingredient*, N.Y. Times, Sept. 17, 2009, at A33..... 8

In the Supreme Court of the United States

No. 14-114

DAVID KING, ET AL., PETITIONERS

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF HEALTH CARE POLICY HISTORY SCHOLARS AS AMICI CURIAE SUPPORTING RESPONDENTS

INTEREST OF AMICI CURIAE[1]

Amici curiae are 36 scholars who study the history of health care policy in the United States. Amici come from varied academic disciplines, including health policy, health economics, law, political science, and history. All have written books or articles examining the development of U.S. health care policy. Many of amici have studied previous attempts at the state and

[1] No counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than the amici curiae, or their counsel, made such a monetary contribution. The parties have filed with the Clerk notices of blanket consent to the filing of amicus curiae briefs. A full list of amici curiae appears in the Appendix to this brief.

national level to expand access to health care, and some personally participated in those reform efforts. All followed, and some personally participated in, the development of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (ACA or Act).

Amici's scholarship and experience lead them to conclude that Congress learned from the failures of previous attempts by States to reform health insurance markets. In particular, Congress understood that expanding access to private health insurance coverage could not fully succeed unless individuals were provided subsidies to make coverage affordable. Relatedly, the historical record of the Act's development makes clear that Congress intended those subsidies to be available in all States, not just in those that elected to operate their own exchange. Because that historical record is relevant under this Court's precedents, its presentation in this brief is likely to assist the Court.

SUMMARY OF ARGUMENT

Petitioners contend that subsidies are unavailable for health coverage purchased on a federally-facilitated exchange. That claim contradicts the ACA's legislative record, which is replete with material inconsistent with petitioners' understanding, and which lacks all evidence that any Member of the Congress that debated, amended, and voted on the bills that culminated in the ACA shared petitioners' understanding. The silence is unusually noteworthy. As this Court has recognized, some issues have such central and enormous policy consequence for the legislation under consideration that they could not have escaped all mention during lengthy deliberations. Withholding subsidies for individual coverage purchased on an exchange is such an

issue because experience from the States' health reform efforts taught, and the bills' drafters understood, that an unsubsidized exchange cannot succeed. Despite many occasions on which withholding of subsidies would have naturally been mentioned—in the legislation itself, in committee reports, during negotiations, or in floor statements by Members supporting and opposing the Act—petitioners cannot point to any such material supporting their understanding. The only reasonable inference is that the 111th Congress shared and intended the government's understanding of the uniform availability of subsidies.

ARGUMENT

Considered against the backdrop of previous health reform efforts, the legislative evolution of the ACA speaks forcefully and directly to the question presented. The legislative record—the evolution of the Act's text, what Members of Congress said about proposed legislation, and, equally significant, what was *never* said—establishes that Congress intended to give premium tax credits to individuals who purchase coverage on a federally-facilitated exchange. This brief begins by describing the health policy history that shaped health reform efforts in the 111th Congress, then turns to the legislative evolution of the ACA itself, and finally draws lessons from the legislative record directly relevant to this case.

I. Drawing On Earlier State Experience, The 111th Congress Subscribed To The Widespread Consensus That Coverage Subsidies Were A Necessary Component Of Politically Feasible Health Reform

An early indication of the direction for health reform legislation in the 111th Congress proved to be a

white paper released by Senator Max Baucus, Chairman of the Senate Finance Committee, shortly after the 2008 election. Max Baucus, *Call to Action: Health Reform 2009* (Nov. 12, 2008) (*White Paper*).[2] It set out Senator Baucus's particular vision, but the key policy elements reflected a widely held consensus about the nature of health reform that, under prevailing political conditions, could realistically be enacted into law. That consensus emerged from a long history of health reform theory and experience, including "managed competition" proposals from the 1970s and 1980s, the failed Clinton reform legislation in the 1990s, mostly unsuccessful state reforms in the 1990s, and the largely successful Massachusetts health care law of 2006. See Jill Quadagno, *Right-Wing Conspiracy? Socialist Plot? The Origins of the Patient Protection and Affordable Care Act*, 39 J. Health Pol. Pol'y & L. 35 (2014) (*Origins of the ACA*).

A. The *White Paper* recognized that efforts to expand insurance coverage needed to focus on minimally disruptive reforms that ameliorated the Nation's dysfunctional individual insurance market and expanded Medicaid. Politically speaking, neither progressive notions of a universal, government-run, "single payer" program nor conservative proposals to transform the existing employer-based system into a universal consumer-driven market were feasible. Because most Americans already enjoyed satisfactory health coverage through employers or under government programs such as Medicare or Medicaid, proposals that would disrupt existing coverage would be poorly received. See Paul Starr, *Remedy and Reaction: The Peculiar*

---

[2] http://finance.senate.gov/download/?id=916b0ea3-96dc-4c7a-bb35-241fa822367e.

American Struggle over Health Care Reform 174-181 (2011) (*Remedy and Reaction*).

Operating within those constraints, the *White Paper* articulated three key elements of what would emerge as the ACA. The first element was reform of the individual health insurance market, in which sick individuals lacked access to affordable coverage (or, often, any coverage). For health coverage to be universally available in the individual market, coverage exclusions for preexisting conditions and the practice of "medical underwriting" could not continue. *White Paper* 19. The necessary policy responses were requiring that coverage be available to all applicants (known as "guaranteed issue") and to require that premiums be set without regard to the applicant's health status (known as "community rating"). See *Nat'l Fed'n of Indep. Bus.* v. *Sebelius*, 132 S. Ct. 2566, 2585 (2012) (*NFIB*).

The second element followed from the first. Market reforms alone could "impose massive new costs on insurers, who [would be] required to accept unhealthy individuals but prohibited from charging them rates necessary to pay for their coverage," which would predictably "lead insurers to significantly increase premiums on everyone." *NFIB*, 132 S. Ct. at 2585. States' experience bore this out. Those that had adopted guaranteed issue for individuals, without subsidies or a purchase mandate, saw premiums soar and coverage shrink dramatically, a self-reinforcing "death spiral" that threatened market collapse. See Leigh Wachenheim & Hans Leida, Milliman, Inc., *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets* 4-42 (Aug.

2007);[3] see also Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts*, 25 J. Health Pol. Pol'y & L. 133 (2000).

The solution was expanding the insurance risk pool with an insurance purchase mandate to encourage healthy and unhealthy individuals alike to purchase coverage. *White Paper* 15-16. Such a mandate—ultimately implemented in the ACA as a tax penalty—had long enjoyed wide acceptance among economists and conservative politicians, commentators, and intellectuals. See, *e.g.*, *Origins of the ACA*, 39 J. Health Pol. Pol'y & L. at 37-41; Mark V. Pauly et al., *A Plan for Responsible National Health Insurance*, Health Aff., Spring 1991, at 5, 6-25; Stuart M. Butler, *Assuring Affordable Health Care for All Americans*, 218 The Heritage Lectures 1, 2, 3, 6 (1989).[4]

The *White Paper*'s third element "recognize[ed] that individuals cannot be made to purchase what they cannot afford," *Halbig* v. *Burwell*, 758 F.3d 390, 419 (D.C. Cir. 2014) (Edwards, J., dissenting). Federal tax law subsidized employer-provided health insurance but not insurance purchased by individuals. See *Remedy and Reaction* 19, 42. Earlier Republican proposals had recognized the need for "adequate subsidies to make health insurance affordable for the poor and the unemployed." Robert F. Bennett et al., *Senate Republican Health Care Task Force Consensus Principles for Health Care Reform* 6 (1993).[5] Drawing on this, the

---

[3] https://www.ahip.org/Issues/Documents/2007/The-Impact-of-Guaranteed-Issue-and-Community-Rating-Reforms-on-Individual-Insurance-Markets.aspx.

[4] http://thf_media.s3.amazonaws.com/1989/pdf/hl218.pdf.

[5] http://legacy.library.ucsf.edu/tid/rzf48d00/pdf.

White Paper reiterated the consensus that means-tested tax credits for insurance premiums—which this brief refers to as "subsidies"—were necessary. *White Paper* 20.

Together, the market reforms, mandate, and subsidies formed an interdependent package of reforms that "state regulators, industry participants, and outside experts" told Congress was workable. Gov't Br. 6. As two of petitioners' amici explain:

> These features of the PPACA's regulatory scheme are inter-dependent. An apt metaphor is that of a three-legged stool: removing any of the three above-mentioned "legs" * * * could cause the structure to collapse. * * * Remove either the individual mandate or the tax credits and the Act's price controls would further threaten the viability of health insurance markets by pushing low-income/low-risk households to exit the market.

Jonathan H. Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA*, 23 Health Matrix 119, 128-129 (2013).

B. The *White Paper* also called for a health insurance "exchange"—a marketplace where individuals and small groups could compare and purchase health insurance plans meeting minimum standards. *White Paper* 17-18.

Such exchanges (or "purchasing cooperatives" or "health alliances") had since the late 1970s been a mainstay of managed competition health reform plans—an arrangement under which a governmental or nongovernmental entity "structures and adjusts [an insurance] market to overcome attempts by insurers to avoid price competition." Alain C. Enthoven, *The His-*

tory and Principles of Managed Competition, Health Aff., Jan. 1993, at 24, 25 (abstract). Exchanges were thus designed to introduce competition and choice into individual insurance markets, providing consumers better and transparent coverage at lower costs. Politically diverse health reformers supported exchanges. See, *e.g.*, Elizabeth Rigby et al., *Party Politics and Enactment of "Obamacare": A Policy-Centered Analysis of Minority Party Involvement*, 39 J. Health Pol. Pol'y & L. 57, 69-70 (2014) (identifying exchanges under the ACA as a Republican proposal); Ron Wyden, *Health Reform's Missing Ingredient*, N.Y. Times, Sept. 17, 2009, at A33.

States' attempts to reform individual and small group markets using exchange structures had failed when they were not accompanied by subsidies. Studies of these failures had concluded that exchanges without subsidies would not work. See, *e.g.*, Richard E. Curtis et al., *Private Purchasing Pools to Harness Individual Tax Credits for Consumers*, 38 Inquiry 159, 161 (2001); Richard E. Curtis et al., *Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?*, Health Aff., Jan. 2001, at 164; Elliot K. Wicks & Mark A. Hall, *Purchasing Cooperatives for Small Employers: Performance and Prospects*, 78 Milbank Q. 511 (2000) (documenting failures of unsubsidized exchanges in Florida, California, Colorado, Texas, and North Carolina).

The policy consensus was accordingly that subsidies were essential to the functioning of an exchange offering individual health coverage. See, *e.g.*, Paul Fronstin & Murray N. Ross, Emp. Benefit Research Inst., *Addressing Health Care Market Reform Through an Insurance Exchange: Essential Policy Components, the Public Plan Option, and Other Issues to Consider* (June

2009);[6] Sally Trude & Paul B. Ginsburg, Center for Studying Health System Change, *Tax Credits and Purchasing Pools: Will This Marriage Work?* (Apr. 2001).[7] Drawing on this understanding, the *White Paper* envisioned that the exchange would not only provide a marketplace for purchasing health coverage, but would also be the mechanism for low and moderate-income individuals to use subsidies to purchase that coverage. *White Paper* 17-18, 20.

C. These measures—market reforms, an individual mandate, subsidies to support the purchase of health coverage, and exchanges—had combined in the successful Massachusetts health reform law. An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts ch. 58. Although those ideas were not original to the Massachusetts law, it was the first to show that such a package of reforms was viable and practical. *Remedy and Reaction* 163-174. Drawing on that experience, the *White Paper* proposed that means-tested subsidies would be available for—but only for—guaranteed-issue, community-rated health coverage plans offering at least a minimum level of benefits and sold through an exchange subject to a purchase mandate. *White Paper* 17-20.

II. The Legislative Evolution Of The Subsidy And Exchange Provisions Of The Affordable Care Act

Senators spent the spring and summer of 2009 drafting bills reflecting the *White Paper*'s framework. The Senate Finance Committee and the Senate Committee on Health, Education, Labor and Pensions

---

[6] http://www.ebri.org/pdf/briefspdf/EBRI_IB_6-2009_Hlth Exchg.pdf.

[7] http://www.hschange.org/CONTENT/306/.

(HELP) share jurisdiction over health legislation. Each committee produced a bill. Elements of those bills were combined into legislation considered by the Senate in late 2009 (which this brief refers to as the merged Senate legislation), and passed with further amendments at the end of 2009. The House passed the same bill in March 2010 as the ACA, which was immediately modified by the Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029. Drawing sound lessons from the legislative history of the subsidy and exchange provisions of the ACA requires an understanding of that legislative evolution, in both its general outline (Part II.A, *infra*) and the particulars of the legislation under consideration (Parts II.B-II.E, *infra*).

A. Overview of the Senate legislative process

1. As the Senate Finance and Senate HELP bills were drafted, the question of the location of the exchange or exchanges—should there be a single nationwide exchange, or one operated in each State?—attracted early attention. The *White Paper* had proposed a single exchange, while endorsing continued state regulation of health plans. *White Paper* iv, 17-18. But despite the arguable advantage of national uniformity that a single exchange would offer, many factors favored creating a separate exchange in each State: health insurance had historically been regulated at the state level, health insurers had state-specific licenses, health insurers had not sold across state lines, and health insurers in practice pooled their risk at the state level. Moreover, as a political matter, some centrist senators believed that establishing a single nationwide exchange risked giving a foothold to future proponents of a single-payer system. See David

K. Jones et al., *Pascal's Wager: Health Insurance Exchanges, Obamacare, and the Republican Dilemma*, 39 J. Health Pol. Pol'y & L. 97, 104 (2014).

Witnesses at Senate hearings likewise emphasized the importance of continued regulation at the state level. See, *e.g.*, *Addressing Insurance Market Reform in National Health Reform (Roundtable Discussion): Hearing of the Committee on Health, Education, Labor, and Pensions*, 111th Cong. 54 (Mar. 24, 2009) (statement of Kansas Insurance Commissioner Sandy Praeger); *Written Comments of Sandy Praeger on Behalf of the National Association of Insurance Commissioners, for the Senate Finance Committee Roundtable Discussion on "Expanding Health Care Coverage"* 3-4 (May 2009). Responding to these and similar comments, all relevant Senate legislation required separate exchanges located in each State.

2. Senate drafters did not take a strong position on who—state officials and contractors or federal officials and contractors—should be responsible for the exchange in each State. Each relevant bill considered by the Senate in 2009 provided for backup federal authority over an exchange if a State did not exercise its authority. No Senate bill contemplated that any State would be without an exchange.

It was widely expected in 2009 that state officials would prefer to maximize their direct control over their State's insurance market by operating the State's exchange. See, *e.g.*, Sean P. Carr, *State Regulators Embrace Health Reforms, but Insist Oversight Remains with Them*, A.M. Best Newswire, Aug. 3, 2009 ("[T]he [National Association of Insurance Commissioners] wants the exchanges managed by the states * * * "). But there was no certainty that all States would do so.

The influential American Legislative Exchange Council (ALEC) had expressed opposition to exchanges in early 2009. See ALEC & Council for Affordable Health Insurance, *2009 State Legislators' Guide to Health Insurance Solutions* 21-22, 38-39.[8] And the very fact that "Congress provided a backup scheme" of federally operated exchanges reflected a recognition that, whatever the reason, "some States might decline * * * to participate in the operation of an exchange." *NFIB*, 132 S. Ct. at 2665 (joint dissent).

No particular concern was expressed about the federal government's capacity to operate exchanges, which would resemble federally operated programs such as Medicare Part C (Medicare Advantage), Medicare Part D (the prescription drug program), and the Federal Employees Health Benefits Program. Still, it was obvious that an exchange operating at the state level might be more politically and practically effective if state officials implemented it, drawing on their valuable historical experience exercising exclusive authority over insurance markets. See generally Act of Mar. 9, 1945 (McCarran-Ferguson Act), ch. 20, 59 Stat. 33, 15 U.S.C. 1011 *et seq.*; *United States* v. *S.-E. Underwriters Ass'n*, 322 U.S. 533 (1944).

Reflecting these considerations, under every relevant Senate bill, insurers would be licensed by States, would form individual and small group risk pools at the state level, and would serve rating areas consisting of States or parts of States. And, under every relevant Senate bill, subsidies would be paid by the federal government, while each State would decide whether it

---

[8] http://www.cahi.org/cahi_contents/resources/pdf/StateLegGuide2009.pdf.

would exercise its authority over its exchange or leave that to the federal government.

B. The Senate HELP Committee bill

The HELP Committee released a narrative of its bill in mid-July and reported a bill in mid-September 2009. See *HELP Health Reform Legislation—Section by Section Narrative* (July 15, 2009) (*HELP Narrative*); S. 1679, 111th Cong. (as reported, Sept. 17, 2009). Under the HELP Bill, subsidies were available to a State's residents in each of three scenarios: First, a State could establish an exchange (which the bill called a "Gateway"), enact the HELP bill's market-reform requirements, and keep state and local government employees off the exchange by offering them employer-based coverage, making it an "establishing State." *Id.* § 3104(b). Second, a State could enact the HELP bill's market-reform requirements, request that the Secretary of Health and Human Services (Secretary) operate the exchange "in such State," and keep government employees off the exchange, making the State a "participating State" once the exchange "established by the Secretary" was operating. *Id.* § 3104(c).

Third, for all other States, subsidies would be available via a "federal fallback" provision. S. 1679 § 3104(d). Residents of those States, during the four years immediately following the bill's enactment, would "not be eligible" for subsidies. *Id.* § 3104(d)(2). But at the end of that period, the Secretary would "establish and operate" an exchange in those States, the HELP bill's market-reform requirements would become effective in those States as a matter of federal law, and those States would each be deemed a "participating State" (just like States that had earlier requested the Secretary's involvement). *Id.* § 3104(d)(1)(A)-

(C). After the Secretary established the exchange, subsidies would be available to the residents of a State subject to the federal fallback provision, provided that the State kept government employees off the exchanges. *Id.* § 3104(d)(1)(D).

Subsidies under the HELP bill would be set by the Secretary, S. 1679 § 3111, and their availability did not depend on whether the State or the Secretary exercised authority over the State's exchange. Rather, as just described, there were essentially two conditions on subsidies: First, they were not available in the absence of an exchange and enactment of market reforms. Second, subsidies would not be available in a State unless the State subjected state and local governmental employers to the Act's employer requirements. *Id.* § 3104(a)(1)(C), (2)(C) & (d)(1)(D). These conditions on federal subsidies were express and unambiguous. See, *e.g.*, *id.* § 3104(d)(2) ("With respect to a State that [elects not to be an establishing or participating State in the four years after enactment], the residents of such State shall not be eligible for [subsidies] until such State becomes a participating State under [§ 3104(d)(1)]."); *id.* § 3104(d)(1)(D) (making subsidies available "if the State agrees to make employers that are State or local governments subject to [the Act's employer mandate]").

C. The Senate Finance Committee bill

1. Senate Finance Committee Chairman Baucus met with key Democratic and Republican Members through the summer and early fall of 2009, hoping to achieve a bipartisan bill. See S. Comm. on Fin., *Health*

Care Reform from Conception to Final Passage 3-4.[9] In those meetings, there was agreement that exchanges would operate at the state level and offer subsidies. See Gail Russell Chaddock, *Senate's "Gang of Six" Key to Healthcare Reform*, Christian Sci. Monitor, Aug. 8, 2009. But as talks stalled in mid-September, Senator Baucus proceeded without Republican support. See Steven Brill, *America's Bitter Pill* 163 (2015). On September 16, 2009, Senator Baucus released the *Chairman's Mark* describing the provisions of his bill.[10] After several weeks of markup hearings, the Finance Committee reported its bill in mid-October. S. 1796, 111th Cong. (as reported, Oct. 19, 2009).

The *Chairman's Mark* consistently referred to the exchanges as "state exchanges." See, *e.g.*, *Chairman's Mark* 20-21 (describing subsidies as being available through the "state exchanges"). But the *Chairman's Mark* was clear that a "state exchange" is simply any exchange that exists within a State or at the state level, irrespective of the entity with authority over it. See, *e.g.*, *Chairman's Mark* 11 ("If a state does not establish an exchange within 24 months of enactment, the Secretary of HHS shall contract with a non-governmental entity to establish a state exchange * * * .").

2. The Finance bill as reported adhered to this usage by providing for exchanges without distinguishing those under state authority and those under federal authority. S. 1796 § 1001 (proposing Social Security Act (SSA) § 2200(2)). Proposed SSA § 2225(b) ("State

---

[9] http://www.finance.senate.gov/imo/media/doc/Health%20Care%20Reform%20Timeline.pdf

[10] http://finance.senate.gov/download/?id=a2b7dd18-544f-4798-917e-2b1251f92abb.

Exchanges") provided that States enacting the Finance bill's market-reform requirements must "establish and have in operation" one or more exchanges. *Ibid.* (proposing SSA § 2225(b)(1)(A)). That section further provided that if a State either (1) does not elect to apply the Finance bill's market-reform requirements, or (2) elects to apply those requirements but does not timely establish the required exchange, then "the Secretary shall enter into a contract with a non-governmental entity to establish and operate the exchanges within the State." *Ibid.* (proposing SSA § 2225(b)(1)(B)); see *ibid.* (proposing SSA § 2225(a)(3)) (applying market reforms as a matter of federal law). All "exchanges" "in operation" were required to "meet[] the requirements of part B [*i.e.*, the proposed SSA Tit. XXII, Pt. B]." *Ibid.* (proposing SSA § 2225(b)(1)(A)).

As for subsidies, the Finance bill defined the annual "premium assistance credit amount" as the sum of monthly premium assistance amounts for "all coverage months" for the taxpayer during the taxable year. S. 1796 § 1205(a) (proposing 26 U.S.C. 36B(b)(1)). It then defined a "coverage month" as a month in which the taxpayer is "covered by a qualified health benefits plan described in subsection (b)(2)(A)(i)." *Ibid.* (proposing 26 U.S.C. 36B(c)(2)(A)(i)). Subsection (b)(2)(A)(i), in turn, described health benefits plans "offered in the individual market within a State * * * which were enrolled in through an exchange established by the State under [proposed SSA Tit. XXII, Pt. B]." *Ibid.* (proposing 26 U.S.C. 36B(b)(2)(A)(i)).

3. The report accompanying the Finance Committee bill echoed the treatment of all exchanges as "state exchanges." It noted that under certain circumstances, "the Secretary would be required to contract with a

nongovernmental entity to establish state exchanges." S. Rep. No. 89, 111th Cong., at 19 (2009) (*Finance Report*). And it explained that subsidies would be available to people "who purchase health insurance through the state exchanges," and "for any plan purchased through the Exchange." *Id.* at 37, 39.

D. The merged Senate legislation

Meetings were held to merge the HELP and Finance bills. The resulting legislation, which would (with amendments not directly relevant here) be enacted as the ACA, largely tracked the Finance bill with respect to subsidies. But the merged Senate legislation drew on the HELP bill in giving the Secretary direct authority over the required state exchange in the event a State did not exercise its authority. The merged legislation was introduced in November on the Senate floor as an amendment to H.R. 3590. S. Am. 2786 to H.R. 3590, 111th Cong. (as introduced, Nov. 19, 2009).

1. With respect to subsidies, the merged Senate legislation drew language verbatim from the Finance bill to define the annual "premium assistance credit amount" as the sum of monthly premium assistance amounts for "all coverage months" for the taxpayer during the taxable year. S. Am. 2786 § 1401 (proposing 26 U.S.C. 36B(b)(1)). Again borrowing from the Finance bill, the merged Senate legislation defined a "coverage month" as a month in which the taxpayer is "covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the * * * Act." *Ibid.* (proposing 26 U.S.C. 36B(c)(2)(A)(i)). And much as in the Finance bill, proposed Section 36B(b)(2)(A) in the merged Senate legislation referred to health benefit plans "offered in the

individual market within a State * * * which were enrolled in through an Exchange established by the State under [section] 1311 of the * * * Act." *Ibid.*

The changes from the Finance bill's subsidy provision were thus twofold, but neither was apparently substantive. First, in proposed 26 U.S.C. 36B(b)(2)(A), what in the Finance bill had been a cross-reference to the federal requirements for exchanges in proposed SSA Tit. XXII, Pt. B became instead a cross-reference to Section 1311 of the merged Senate legislation, which came to house the federal requirements for exchanges. Second, the "enrolled in through an Exchange established by the State" language—which, significantly, was already present in the Finance bill's proposed 26 U.S.C. 36B(b)(2)(A)—was simply duplicated (apparently for stylistic purposes) in the merged Senate legislation's proposed 26 U.S.C. 36B(c)(2)(A)(i). Compare S. Am. 2786 § 1401 (proposing 26 U.S.C. 36B(b)(2)(A) & (c)(2)(A)(i)) with S. 1796 § 1205(a) (proposing 26 U.S.C. 36B(b)(2)(A) & (c)(2)(A)(i)).

As for federal authority over exchanges, Section 1321(c) of the merged Senate legislation mirrored the Finance bill's proposed SSA § 2225(b). Both provided that if a State elects not to establish an exchange or fails to establish an exchange promptly, the Secretary shall "establish and operate" the exchanges "within the State." See S. 1796 § 1001 (proposing SSA § 2225(b)(1)(B)); S. Am. 2786 § 1321(c)(1). Borrowing from the HELP bill instead of the Finance bill, however, the merged Senate legislation gave the Secretary the option of exercising direct authority over the exchange by providing that the Secretary "shall (directly or through agreement with a not-for-profit entity)

establish and operate such Exchange within the State." S. Am. 2786 § 1321(c)(1); S. 1679 § 3101(c).

2. Negotiations continued into December 2009 to reach a bill that could survive a filibuster and pass the Senate. Most negotiations involved centrist Senators whose votes were essential for passage—Senators Ben Nelson, Landrieu, Carper, Pryor, and Lieberman. See John E. McDonough, *Inside National Health Reform* 91-92 (2011). The resulting changes, and others negotiated in the Senate, were housed in Title X of the ACA, introduced in mid-December. See S. Am. 3276 to S. Am. 2786 (as introduced, Dec. 19, 2009). None of those changes affected either Section 1321 or the relevant provisions of Section 1401. H.R. 3590 passed the Senate on December 24, 2009. 155 Cong. Rec. S13891.

E. Passage in the House and the Health Care and Education Reconciliation Act

After passage in the Senate, the question became whether the House would also pass H.R. 3590 or would instead negotiate a bill with the Senate. House committees had advanced health reform legislation in the summer of 2009. See Jonathan Cohn, *How They Did It: The Inside Account of Health Care Reform's Triumph*, The New Republic, June 10, 2010, at 14, 20-21. In November 2009, the House had adopted a bill with all key elements of the Senate bill—market reforms, an individual mandate, subsidies, and exchanges—but unlike Senate proposals, the House bill provided for a single nationwide exchange, while permitting States to create exchanges only with federal approval. H.R. 3962, §§ 301, 308, 111th Cong. (as passed by House, Nov. 7, 2009). H.R. 3590 had escaped a Senate filibuster by the narrowest of margins, so the January 19, 2010, election of Republican Scott Brown to fill the late

Democratic Senator Edward Kennedy's seat left Democrats with no choice but for the House to adopt H.R. 3590 (subject only to limited budget-related changes that could pass the Senate by a simple majority).

The legislative record in the House in early 2010 is sparse, and it does not mention withholding subsidies for coverage purchased on a federally-facilitated exchange. Ultimately, the House adopted H.R. 3590. 156 Cong. Rec. H2153 (Mar. 21, 2010). In late March, both Houses passed HCERA, which affected only one provision relevant here: It amended 26 U.S.C. 36B to revise the numerical formula for computing the tax credit, and—of special relevance here—to make clear that federally-facilitated exchanges, like those under state authority, would report the subsidies they granted, HCERA § 1004(c), 124 Stat. 1035 (adding 26 U.S.C. 36B(f)(3)).

III. The Government's Position Finds Support Both In Affirmative Evidence From The Legislative Record And In The Lack Of Evidence That Any Member Of Congress Shared Petitioners' Understanding Of The Act When It Was Considered And Passed

The background and legislative evolution of the ACA squarely support the government's position because they show that the 111th Congress subscribed throughout to the principle that an exchange cannot succeed without subsidies. This is evident not only from the broad arc of the ACA's development, but from every particular of the legislative record. Contemporaneous reports and analysis are consistent with the government's position and the policy underpinnings of the Act. And the silence speaks loudly too. Petitioners' case largely rests on text in the ACA that traces back to the Finance bill. Yet there is no plausible explana-

tion why (or evidence that) the Finance Committee would have rejected the consensus view that a successful exchange requires subsidies, and threatened to hobble some States' insurance markets with market reforms that Congress knew were counterproductive in the absence of subsidies. And if the Finance bill had made subsidies contingent on a State assuming authority over an exchange, that striking departure from the HELP bill's approach could not have escaped all mention when the bills were merged and during the prolonged debate that followed. The only fair inference from the ACA's history is that the government's interpretation is correct.

A. This Court has appropriately relied on legislative silence to reject proposed statutory interpretations with policy consequences so significant that they could not have escaped comment during the legislative process

This Court has repeatedly recognized that silence in the legislative record is telling when a proposed interpretation of a statute is so surprising that it could not have escaped comment during the legislative process. For example, in *Church of Scientology* v. *IRS*, 484 U.S. 9, 16 (1987), the Court considered a statute with a "major purpose[]" of "tighten[ing] the restrictions on the use of [tax] return information." The definition of "return information" in that statute had been amended on the House floor in a way that the petitioner there contended gave the public surprisingly broad access to a wide range of records maintained by the IRS. The Court rejected that reading of the amendment, in large part because the legislative history was silent, "find[ing] it difficult to believe that Congress in this manner adopted an amendment which would work

such an alteration to the basic thrust of the draft bill." *Id.* at 17. The Court explained that "common sense suggests, by analogy to Sir Arthur Conan Doyle's 'dog that didn't bark,' that an amendment having the effect petitioner ascribes to it would have been differently described by its sponsor, and not nearly as readily accepted by the floor manager of the bill." *Id.* at 17-18.

This Court has, of course, recognized that often "a court cannot, in the manner of Sherlock Holmes, pursue the theory of the dog that did not bark," particularly when the issue does "not appear so large as ineluctably to have provoked comment in Congress." *Harrison* v. *PPG Indus., Inc.*, 446 U.S. 578, 591-592 (1980). But that simply acknowledges the limiting principle on what is otherwise a sound and commonsense line of reasoning. Accordingly, where (1) an issue is inherently likely to have provoked comment, and (2) the legislative deliberations afforded ample opportunity for comment, the Court has readily found "Congress' failure to discuss an issue during prolonged legislative deliberations [to] itself be probative," *City of Rancho Palos Verdes* v. *Abrams*, 544 U.S. 113, 131 (2005) (Stevens, J., concurring in judgment) (citing cases). See, *e.g.*, *Chisom* v. *Roemer*, 501 U.S. 380, 396 & n.23 (1991) (rejecting interpretation of statutory amendment that would depart from existing understanding in part because "at least some of the Members would have identified or mentioned it at some point in the unusually extensive legislative history of the * * * amendment") (citing A. Doyle, *Silver Blaze*, in *The Complete Sherlock Holmes* 335 (1927)); *Sedima, S.P.R.L.* v. *Imrex Co.*, 473 U.S. 479, 490 (1985) (reasoning that "[h]ad Congress intended to impose [a particularly significant] requirement [on certain civil actions], there

would have been at least some mention of it in the legislative history, even if not in the statute").

B. The legislative record conspicuously lacks any suggestion that Members understood the Act or predecessor bills as petitioners do, and indeed it speaks affirmatively against their position

Part I above explains how Congress began from the premise, made explicit in the *White Paper*, that subsidies on exchanges were necessary for successful reform of the individual insurance market; without them, experience showed the three-legged stool would not stand. That understanding was implicit, explicit, and unquestioned in the legislative record, from the opening of the 111th Congress to the enactment of the ACA and HCERA. Indeed, the legislative record is conspicuously silent in numerous places where a subject as important as withholding of subsidies would have been discussed—especially if, as petitioners contend, Congress intended to coerce States into assuming authority over exchanges by threatening to withhold subsidies for their residents.

1. The Senate HELP bill did not withhold subsidies for coverage purchased on state-level exchanges under federal authority, and petitioners do not contend otherwise. See Pet. Br. 41. But it did condition subsidies on the existence of an exchange and the enactment of market reforms, and on the State subjecting state and local government employers to the ACA's employer requirements. See pp. 13-14, *supra*.

Although the HELP bill was not enacted, it offers three lessons. First, it shows that Senate drafters knew how to condition subsidies on a State taking particular action, and drafters made those conditions explicit and unambiguous in the provisions addressing

exchanges. See, *e.g.*, S. 1679 § 3104(d)(2) (describing circumstances under which "residents of [a] State shall not be eligible for [subsidies]"). Second, withholding of subsidies was so significant that it merited mention in descriptions of the HELP bill. See, *e.g.*, *HELP Narrative* 4 ("Until a state becomes either an establishing or participating state, the residents of that state will not be eligible for [subsidies] * * * "). Third, the HELP bill did not use subsidies to coerce States at the risk of a policy failure. Rather, subsidies were withheld until circumstances assured that their expenditure would serve Congress's goals of funding only coverage satisfying the bill's market reforms, purchased under the managed competition framework of an exchange, and not subsidizing state and local workers whose coverage should be provided by their governmental employer.

2. Petitioners hang their case on the phrase "established by the State" in 26 U.S.C. 36B. Because that phrase traces to the Senate Finance bill (see pp. 16, 17-18, *supra*), petitioners' reading of the ACA as enacted implies that the Finance bill also withheld the subsidies at issue in this case. Yet petitioners have no satisfactory account of why, with respect to those subsidies, the drafters of the Finance bill would have abandoned the consensus on which the health reform legislation was constructed, departed from the approach of the HELP bill, and reversed course from the approach laid out by the Finance Committee Chairman himself in his own *White Paper*—all without the slightest mention in the legislative record.

No witness testimony in the Finance Committee's hearings in 2009 addresses the topic of withholding subsidies in the way petitioners propose. The *Chairman's Mark* says nothing about withholding subsidies.

And the Finance bill itself has no text comparable to the HELP bill's text that expressly withholds subsidies under specified circumstances—despite any number of places in the Finance bill that could have housed provisions comparable to those in Section 3104 of the HELP bill. Indeed, even apart from the HELP bill's model of a provision withholding subsidies, *the Finance bill itself* used explicit and unambiguous language when withholding subsidies. See S. 1796 § 1221(a) (proposing 26 U.S.C. 45R(c)(2) ("No [tax] credit [for a small employer] shall be determined under this section [until] the State establishing the exchange has in effect [certain market reforms].")).

Moreover, if the Finance bill differed from the HELP bill by withholding subsidies in the way petitioners assert, the subject would have been raised during the *weeks* of markup hearings in the Finance Committee. It was not. And, if the Finance bill withheld subsidies as petitioners claim, then the *Finance Report* would have said so, just as the *HELP Narrative* made clear that subsidies would be unavailable under certain other circumstances. But the *Finance Report* did not: not in discussing the consequences of a State's failure to enact market reforms or exercise authority over an exchange (*Finance Report* 18-19), not in describing systems for determining eligibility for subsidies (*id.* at 26, 28-29), and not in discussing the subsidies themselves (*id.* at 37-39). Rather, using the generic umbrella terms "state exchange" and "exchange" (see pp. 16-17, *supra*) the *Finance Report* flatly stated that subsidies would be available to all "who purchase health insurance through the state exchanges" and "for any plan purchased through the Exchange" (*Finance Report* 37, 39).

3. Members of Congress asked the Congressional Budget Office (CBO) to project the costs of various health reform legislation. CBO's analyses generally assumed that subsidies would be available nationwide. See, *e.g.*, CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 7 (Nov. 30, 2009). The CBO's Director later acknowledged "CBO's assumption that the premium assistance tax credits * * * would be available in every state, including states where the insurance exchanges would be established by the federal government." Letter from Douglas W. Elmendorf to Hon. Darrell E. Issa (Dec. 6, 2012) (Elmendorf Letter).

More telling than what CBO did do, however, is what it did not: No evidence exists that, despite some 68 CBO analyses of health reform legislation in 2009 and 2010, any Member of Congress ever asked the CBO to project costs on the assumption that subsidies would be unavailable for coverage purchased on federally-facilitated exchanges. See Theda Skocpol, *Why Congressional Budget Office Reports Are the Best Evidence of Congressional Intent About Health Subsidies*;[11] Elmendorf Letter ("To the best of our recollection, the possibility that * * * subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff * * * "). Yet the proponents of health reform legislation had ample reason to ask for such projections because they would have reduced the legislation's cost, perhaps substantially. See generally Lisa Schultz Bressman &

---

[11] http://www.scholarsstrategynetwork.org/sites/default/files/ssn_basic_facts_skocpol_on_cbo_reports_as_evidence_about_health_subsidy_intent_finalfinal.pdf.

Abbe R. Gluck, *Statutory Interpretation from the Inside: An Empirical Study of Congressional Drafting, Delegation and the Canons: Part II*, 66 Stan. L. Rev. 725, 763-765 (2014) (describing relationship between congressional staffers and CBO).

Petitioners and their amici protest that CBO's projections might not be inconsistent with their position because CBO might have assumed that all States would set up exchanges. See, *e.g.*, Pet. Br. 43. But that is beside the point. Tacit assumptions by *CBO* about States' behavior would not illuminate what *Members of Congress* understood their legislation to provide by way of federal action if CBO's assumptions proved *wrong*.

4. After the Finance and HELP bills reached the Senate floor, there was again no suggestion in the legislative record that subsidies would be unavailable for coverage purchased on a federally-facilitated exchange.

a. The negotiations that produced the merged Senate legislation provided every opportunity for Senators to signal that subsidies might be withheld in some States. Under any scenario, the issue would have received prominent attention. On the one hand, if the Finance bill withheld subsidies for coverage purchased on a federally-facilitated exchange and (as all agree) the HELP bill did not, then reconciling the two would have been a crucial topic of discussion, especially given the uniform understanding of the importance of subsidies. But it was not identified as an issue under discussion. See, *e.g.*, Marilyn Werber Serafini & Bara Vaida, *Eight Key Hurdles for Health Care Overhaul*, Nat'l J., Nov. 20, 2009. Indeed, it would have been a live topic long before then—either during the Finance

Committee markup hearings (which occurred after the HELP bill was reported out), or once the Finance bill was reported out in October 2009. But no Senator ever suggested the HELP and Finance bills differed on the issue.

On the other hand, if the bills did not differ—if neither withheld subsidies for coverage purchased on a federally-facilitated exchange—then petitioners' position reduces to a claim that withholding subsidies was an innovation of the merged Senate legislation alone. That is implausible. As a matter of policy, it would have reflected a radical yet tacit rejection of all that had gone before. As a matter of politics, it would have required proponents of uniform nationwide subsidies to give a secret concession to the subsidies' (unnamed) opponents, with all agreeing never to speak of that concession and to affirmatively obscure it. And as a matter of drafting, the merged Senate legislation would not have so closely resembled the Finance bill, but instead would have adapted the HELP bill's existing language withholding subsidies under other circumstances, or mirrored the language the Finance bill had proposed for 26 U.S.C. 45R (see p. 25, *supra*).

b. The Senators who participated in the debates—both supporters and opponents of the merged Senate legislation—assumed that subsidies would be available. Many opponents invoked figures from the CBO's projections (which assumed that subsidies would be available nationwide, see p. 26, *supra*) in criticizing the legislation's cost. See, *e.g.*, 155 Cong. Rec. S11916 (Nov. 21, 2009) (Sen. Thune); 155 Cong. Rec. S12107 (Dec. 2, 2009) (Sen. Grassley); 155 Cong. Rec. S12378 (Dec. 4, 2009) (Sen. Enzi). And supporters and opponents alike stated without contradiction that subsidies

would be available in every State. Senator Bingaman explained that the law would create "a new health insurance exchange in each State which will provide Americans a centralized source of meaningful private insurance as well as refundable tax credits to ensure that coverage is affordable." 155 Cong. Rec. S12358 (Dec. 4, 2009); see 155 Cong. Rec. S12799 (Dec. 9, 2009) (Sen. Johnson); Gov't Br. 45 (citing floor statement and *Wall Street Journal* opinion piece by Senator Hatch).

Those statements were not made on the assumption that each State would establish its own exchange directly. To the contrary, Senators on both sides of the debate emphasized that the Secretary would set up exchanges in States that had failed to do so. See, *e.g.*, 155 Cong. Rec. S13832 (Dec. 23, 2009) (Sen. Baucus) (explaining that "States [would have] the choice to participate in the exchanges themselves or, if they do not choose to do so, to allow the Federal Government to set up the exchanges"); 155 Cong. Rec. S13726 (Dec. 22, 2009) (Sen. Hatch) ("[T]he legislation orders states to establish health benefit exchanges" and "[i]f they do not, or even if the Secretary * * * believes they will not by a certain date, the Secretary will literally step into each state and establish and operate this exchange for them.").

5. When focus shifted to the House in early 2010 after the Senate passed H.R. 3590, the silence in the legislative record persisted. The silence from the House is particularly notable because subsidies were unquestionably uniform under the House legislation, and it had become clear by the end of 2009 that if the Senate approach prevailed, some exchanges would likely be under federal authority. See Gov't Br. 42. Yet a late 2009 analysis by House staff of the differ-

ences between the House and Senate legislation did not suggest that the Senate's approach would affect subsidies. Tri-Committee House Staff, *House-Senate Comparison of Key Provisions* (Dec. 29, 2009).

The few documents in the legislative record from early 2010 also support the government's position. For example, a March 20, 2010, House Energy and Commerce Committee synopsis of "The Health Insurance Exchanges" stated without qualification that subsidies would be available through the exchanges and that the federal government would run an exchange "[f]or states that choose not to operate their own exchange."[12]

Finally, as petitioners' amici acknowledge (Adler & Cannon Amicus Br. 12-13), HCERA would have presented an opportunity to correct any perceived failure in the ACA to provide subsidies for coverage purchased on a federally-facilitated exchange. The absence of any effort in the House to craft HCERA to provide such subsidies suggests the ACA already provided them, as the reporting provisions of HCERA corroborate, see p. 20, *supra*; Gov't Br. 25-26.

C. Petitioners and their amici fail to identify sound evidence that any Member of Congress shared their understanding of the Act when it was considered and passed

The few scattered sources on which petitioners and their amici rely do not fill the vacuum in the legislative record on a subject that, if petitioners were correct, would have been a central point of contention throughout the 111th Congress. Most of their account of legislative purpose and history is mere speculation that

---

[12] http://housedocs.house.gov/energycommerce/EXCHANGE.pdf.

cannot be squared with actual events. And they misconstrue what little contemporaneous evidence they offer.

1. Petitioners and their amici have generally coalesced around a hypothesis that the ACA's supposed withholding of subsidies from residents of some States emerged as a hybrid effort to coerce States into taking authority over exchanges, while mollifying centrist Senators (especially Senator Ben Nelson) who opposed a single nationwide exchange. See, *e.g.*, Pet. Br. 1, 4, 14, 42; Adler & Cannon Amicus Br. 3, 22-28, 30; Cornyn Amicus Br. 12, Missouri Liberty Amicus Br. 9-13. That notion is ahistorical and riddled with conceptual flaws.

a. To begin with, it is impossible to fit that claim about Senator Nelson into the actual timeline of events. The text of the ACA on which petitioners rely was present in the Finance bill (which was reported in mid-October 2009) and the merged Senate legislation (which was introduced in mid-November 2009). Negotiations with Senator Nelson could not have prompted the Senate to adopt petitioners' understanding for the first time in December 2009.

Nor do petitioners' claims square with the substance of Senator Nelson's concerns. The concessions to Senator Nelson (embodied in S. Am. 3276, introduced on December 19, 2009) addressed other subjects. David Espo & Richard Alonso-Zaldivar, *Nelson Supports Health Bill After Tough Bargaining*, Associated Press, Dec. 19, 2009 ("Nelson said he made his decision after winning fresh concessions to limit the availability of abortions in insurance sold in newly created exchanges, as well as tens of million in federal money to

cover Nebraska's cost of treating patients in Medicaid * * * .").

Petitioners and their amici distort Senator Nelson's position on exchanges in arguing that, because he disfavored a single exchange, he supported state-level exchanges *only when run by States*. See, *e.g.*, Pet. Br. 4. Not so. Senator Nelson meant just what he said: a single nationwide exchange was unacceptable. See Carrie Budoff Brown, *Nelson: National Exchange a Dealbreaker*, Politico, Jan. 25, 2010. That view was fundamentally at odds with the House bill, but what mattered to Senator Nelson had already been settled, in every version of Senate legislation, in favor of state-level exchanges that would not threaten to evolve into a single-payer system. And at no time before the Act's passage did Senator Nelson—or any other Senator—assert that subsidies would or should be unavailable for coverage purchased on federally-facilitated exchanges.

b. The other half of petitioners' hypothesis—that Congress used the threat of withholding subsidies as a coercive weapon—also fails. To begin with, Members conscious of the States' sovereign dignity would not subject States to the coercion petitioners say the ACA embodies; the government has rightly exposed petitioners' rhetoric as faux federalism. Gov't Br. 38-41, 43-45, 51. More fundamentally, Congress did not play chicken with the States over a core part of the ACA. Subsidies were indispensable to the operation of the Senate's legislation; who exercised authority over the exchanges was negotiable. And the hard policy lessons from States' experiences with health reform made clear that gambling on the availability of subsidies risked a death spiral that would make matters worse than

before, with market reforms in place but no subsidies to support a viable individual insurance market. See Gov't Br. 37.

Petitioners' amici contend that their interpretation of 26 U.S.C. 36B fits a pattern of "[c]onditioning individual benefits on state cooperation with federal priorities." Adler & Cannon Amicus Br. 22. But the conditions they identify, including some from the HELP and Finance bills (*id.* at 25-27), differ fundamentally from what they say Section 36B does. In amici's examples, the federal spending or subsidy is contingent on the State taking measures that assure that federal money will be used as Congress intended. Such conditions on federal money are intended to protect federal expenditures, not to extort state compliance as an end in itself. What amici miss is that Congress did not need similar assurances and protections here because, under the ACA and every version of the relevant Senate legislation, the market reforms, individual mandate, and exchanges would eventually go into effect *whether or not* a State exercised authority over its exchange. Petitioners and their amici would thus attribute to 26 U.S.C. 36B a uniquely coercive status that Congress did not intend.

2. Petitioners' amici's preferred contemporaneous written evidence (Adler & Cannon Amicus Br. 28-30) is a lone January 10, 2010, open letter to the President from Texas's Democratic House delegation, which preferred the single nationwide exchange provided in H.R. 3962. The letter expressed concern that because H.R. 3590 (which the Senate had passed just two weeks earlier) provided for state-level exchanges, States might "obstruct[]" implementation in a way that could leave "millions of people * * * no better off than

before Congress acted." *U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans*, My Harlingen News, Jan. 11, 2010 (Doggett Letter).[13]

The Doggett Letter is unilluminating because it does not specify the "obstruction" its authors feared. The short letter does not mention withholding subsidies at all. Rather, it expresses concern about some States' budgetary fortitude and capability to wisely implement health coverage programs, and it argues the economic virtues of a single exchange.

The letter's context is equally important. In early January 2010, it was widely assumed that Democrat Martha Coakley would soon fill Senator Kennedy's seat. See Matt Viser & Frank Phillips, *Senate Poll: Coakley Up 15 Points*, Boston Globe, Jan. 10, 2010. House and Senate leaders therefore were actively engaged with the White House to negotiate the differences between the exchange structures of the House legislation and the Senate legislation. See Jonathan Cohn, *One More Clue that the Obamacare Lawsuits Are Wrong*, New Republic, July 28, 2014.[14] The dynamic shifted when Republican Scott Brown upset Coakley in late January, but at the time the letter was sent, it was calculated not so much to accurately characterize the Senate's legislation as to urge the President that the House approach was superior. See Doggett Letter ("[T]he bill we pass should include a single, national health insurance exchange, as [in H.R. 3962].").

3. Tellingly, petitioners and their amici rely much more on non-legislators' statements than on Members'

---

[13] http://www.myharlingennews.com/?p=6426.

[14] http://www.newrepublic.com/article/118867/email-house-aide-undermines-halbig-lawsuit-obamacare-subsidies.

own words. Their leading reference (*e.g.*, Pet. Br. 4, 42) is to an excerpt of remarks by economist Jonathan Gruber in 2012 that seemingly accords with petitioners' interpretation of the Act. Petitioners lionize Professor Gruber as a "key architect" of the Act and on that basis would treat his statements as authoritative. But post-enactment statements by non-legislators are "not a legitimate tool of statutory interpretation." *United States* v. *Woods*, 134 S. Ct. 557, 568 (2013) (citation omitted). And, as Professor Gruber has explained, when restored to their original context, his remarks were premised on "the possibility that the federal government * * * might not create a federal exchange"—as appeared possible when he made his comments, and which indeed would have frustrated the delivery of subsidies. *Written Testimony of Professor Jonathan Gruber Before the Committee on Oversight and Government Reform, U.S. House of Representatives* 2 (Dec. 9, 2014). In any event, Professor Gruber was not a legislative draftsman; as every reference to him in the *Congressional Record* attests, he was an "economist" or an "outside expert" in computer modeling.

Finally, petitioners cite (Pet. Br. 41) an early 2009 paper observing that Congress could encourage States to establish exchanges "by offering tax subsidies for insurance only in states that complied with federal requirements." Timothy Stoltzfus Jost, *Health Insurance Exchanges: Legal Issues*, O'Neill Inst. for Nat'l and Global Health Law, Georgetown Univ. Legal Ctr., no. 23, at 7 (Apr. 7, 2009) (*Health Insurance Exchanges*). "There is no evidence, however, that anyone in Congress read, cited, or relied on this article." *Halbig*, 758 F.3d at 426 (Edwards, J., dissenting). And the

paper's other suggestions (*Health Insurance Exchanges* 7) were that "Congress could invite state participation in a federal program, and provide a federal fallback program" and "offer[] [grants] to states that establish exchanges"—which, it turns out, is exactly what Congress did.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

BENJAMIN J. HORWICH
GUHA KRISHNAMURTHI
JOHN F. MULLER
MUNGER, TOLLES & OLSON LLP
560 Mission Street
27th Floor
San Francisco, CA 94105
ben.horwich@mto.com
(415) 512-4000

OF COUNSEL:

MARK REGAN
DISABILITY LAW CENTER OF ALASKA
3330 Arctic Blvd.
Suite 103
Anchorage, AK 99503
(907) 565-1002

JANUARY 2015

APPENDIX

APPENDIX

LIST OF AMICI CURIAE

William P. Brandon, Emeritus MMF Distinguished Professor of Public Policy, Department of Political Science & Public Administration and Public Policy PhD Faculty, University of North Carolina Charlotte

Andrea Louise Campbell, Professor of Political Science, Massachusetts Institute of Technology

Daniel Carpenter, Allie S. Freed Professor of Government, Faculty of Arts and Sciences, Harvard University

Stephen M. Davidson, Professor, Boston University School of Management

Judith Feder, Professor, Georgetown University McCourt School of Public Policy and Urban Institute Fellow

Robert I. Field, Professor of Law and Professor of Health Management and Policy, Thomas R. Kline School of Law and School of Public Health, Drexel University

Colin Gordon, Professor, University of Iowa Department of History

Bradford H. Gray, Senior Fellow, The Urban Institute

Colleen Grogan, Professor, School of Social Service Administration, University of Chicago

Jacob Hacker, Stanley B. Resor Professor of Political Science and Director, Institution for Social and Policy Studies, Yale University

Mark Hall, Professor of Law and Public Health, Wake Forest University

Beatrix Hoffman, Professor of History, Northern Illinois University

David K. Jones, Assistant Professor, Health Policy & Management, Boston University School of Public Health

Timothy Stolzfus Jost, Professor, Washington and Lee University School of Law

Jennifer Klein, Professor, Department of History, Yale University

Miriam J. Laugesen, Assistant Professor of Health Policy and Management, Columbia University Mailman School of Public Health

Theodore R. Marmor, Professor, Yale University School of Management

Rick Mayes, Associate Professor, School of Nursing, University of Virginia and Co-Director, Healthcare & Society Program, University of Richmond

John E. McDonough, Professor of Practice, Harvard TH Chan School of Public Health

David Mechanic, René Dubos University Professor of Behavioral Sciences and Founding Director of the Institute for Health, Health Care Policy, and Aging Research, Rutgers University, The State University of New Jersey

Edward Alan Miller , Associate Professor of Gerontology and Public Policy, and Fellow, Gerontology Institute, John W. McCormack Graduate School of Policy & Global Studies, University of Massachusetts Boston

Kimberly J. Morgan, Associate Professor of Political Science and International Affairs, The George Washington University

Jonathan Oberlander, Professor and Vice Chair of Social Medicine and Health Policy & Management, University of North Carolina-Chapel Hill

Thomas R. Oliver, Professor of Population Health Sciences, School of Medicine and Public Health, University of Wisconsin-Madison

Mark A. Peterson, Professor of Public Policy, Political Science, and Law, Department of Public Policy, UCLA Luskin School of Public Affairs

Harold Pollack, Helen Ross Professor, School of Social Service Administration and Public Health Sciences, University of Chicago

Jill Quadagno, Mildred and Claude Pepper Eminent Scholar in Social Gerontology, Pepper Institute on Aging and Public Policy, Florida State University

Mark Schlesinger, Professor of Health Policy, Yale University School of Public Health

David Shactman, Retired, former Senior Fellow, Schneider Institute for Health Policy, Brandeis University

Theda Skocpol, Victor S. Thomas Professor of Government and Sociology, Harvard University

David Barton Smith, Professor Emeritus, Department of Risk, Insurance and Health Care Management, Temple University, Adjunct Professor Drexel University School of Public Health

Michael S. Sparer, Professor, and Chair of Health Policy and Management, Mailman School of Public Health, Columbia University

Paul E. Starr, Professor of Sociology and Public Affairs and Stuart Professor of Communications and Public Affairs, Princeton University

Deborah Stone, Lecturer in Public Policy, Massachusetts Institute of Technology, Department of Urban Studies and Planning

Keith Wailoo, Townsend Martin Professor of History and Public Affairs, Vice Dean, Woodrow Wilson School of Public and International Affairs, Princeton University

Joseph White, Chair, Department of Political Science, Luxenberg Family Professor of Public Policy, Professor of Epidemiology and Biostatistics, and Director of Center for Policy Studies, Case Western Reserve University